SISTER THEA BOWMAN CATHOLIC ACADEMY
PARENT QUESTIONNAIRE

CHILD'S NAME_____ BOY____ GIRL____
(FIRST) (LAST)

BIRTHDATE_____
Month/Day/Year

MOTHER'S NAME_____ OCCUPATION_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

ADDRESS_____CITY_____ZIP_____

CHILD RESIDES WITH: _____MOTHER _____FATHER _____LEGAL GUARDIAN

FULL TIME_____ IF NOT, PLEASE EXPLAIN_____

FATHER'S NAME_____ OCCUPATION_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

ADDRESS_____CITY_____ZIP_____

LEGAL GUARDIAN'S NAME_____ OCCUPATION_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

ADDRESS_____CITY_____ZIP_____

SIBLINGS

NAME_____AGE_____GRADE_____SCHOOL_____

NAME_____AGE_____GRADE_____SCHOOL_____

NAME_____AGE_____GRADE_____SCHOOL_____

NAME_____ AGE_____GRADE_____SCHOOL_____

DATE OF LAST DOCTOR EXAM_____ HEIGHT_____ WEIGHT_____

LIST ANY MEDICATIONS THAT YOUR CHILD TAKES REGULARLY AND WHY IT IS NEEDED

_____

_____

WERE THERE ANY COMPLICATIONS WITH THE PREGNANCY OF THIS CHILD?
YES/NO IF YES, PLEASE EXPLAIN_____

HAS THIS CHILD EVER REQUIRED ANY SPECIAL MDICAL CARE OR HOSPITALIZATIONS?
YES/NO IF YES, PLEASE EXPLAIN_____

DO YOU HAVE ANY CONCERNS WITH THIS CHILD'S HEARING?
YES/NO IF YES, PLEASE EXPLAIN_____

DO YOU HAVE ANY CONCERNS WITH THIS CHILD'S VISION?
YES/NO IF YES, PLEASE EXPLAIN_____

AT WHAT AGE DID THIS CHILD BEGIN TOILET TRAINING? _____ COMPLETED? YES/NO

HAS YOUR CHILD BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING:
(PLEASE CIRCLE ALL THAT APPLY)

ALLERGIES
ANXIETY
ASTHMA
BEDWETTING
DIGESTIVE PROBLEMS
EAR INFECTION
FATIGUE
FREQUENT FEVERS
HEADACHES
HEARING PROBLEMS
HEART PROBLEMS
HYPERACTIVITY
NIGHTMARES
NOSE BLEEDS
POOR APPETITE
SEIZURES
SINUS PROBLEMS
THUMB SUCKING
VISION PROBLEMS

AT WHAT AGE DID THIS CHILD SAY HIS/HER FIRST WORDS_____
PUT 2 AND 3 WORDS TOGETHER_____ SAY SENTENCES_____

OTHER THAN ENGLISH, ARE THERE OTHER LANGUAGE(S) SPOKEN/UNDERSTOOD IN YOUR HOME? YES/NO
IF YES, WHAT LANGUAGE(S)_____

DOES YOUR CHILD (PLEASE CHECK ONE)	YES	NO	NOT SURE
SING LITTLE SONGS OR COMMERCIALS			
CRY OR WHINE			
SEEM TO BE UNUSUALLY QUIET			
REPEAT ACTIONS OR WORDS NEEEDLESSLY			
PAY ATTENTION TO WHAT YOU SAY OR DO			
SEEM TO BE RESTLESS OR FIDGETY			
SEEM TO BE HAPPY			
SAY "I CAN'T" WITHOUT TRYING			
HAVE TEMPER TANTRUMS			
SEEM TO BE A LEADER			
CRY WHEN NOT GIVEN HIS/HER WAY			
MOVE SLOWLY			
ACT WITHOUT REASON, ON THE SPUR OF THE MOMENT			
PLAY WELL WITH OTHER CHILDREN			
GET UPSET EASILY			
HAVE MANY UNUSUAL OR DIFFERENT IDEAS			
ABILITY TO SEPARATEFROM PARENT OR CAREGIVER			
CAN COOPERATE WITH ADULTS			
ABILITY TO SIT AND PLAY FOR SHORT PERIODS OF TIME			
CAN PLAY INDEPENDENTLY			

WHAT ARE YOUR CHILD'S FAVORITE ACTIVITIES AT HOME

_____

DOES YOUR CHILD PREFER TO PLAY ALONE OR WITH OTHERS_____

HOW DOES YOUR CHILD GET ALONG WITH SIBLINGS AND PLAYMATES_____

DO YOU HAVE ANY CONCERNS ABOUT THIS CHILD (FEARS, BEHAVIORS, ETC)_____

DOES THIS CHILD ATTEND PRESCHOOL YES/NO

IF YES, WHERE_____HOW LONG_____

IF NO, ARE THERE FINANCIAL CIRCUMSTANCES THAT MAKE IT DIFFICULT YES/NO

LIST ANY OTHER REASONS YOUR CHILD DOES NOT ATTEND PRESCHOOL_____

DOES ANYONE READ STORIES TO THIS CHILD? YES/NO WHO_____

HOW MANY HOURS EACH DAY DOES YOUR CHILD WATCH TV_____

WHAT DO THEY WATCH_____

DOES YOUR CHILD KNOW (CIRCLE ALL THAT APPLY) ABC'S COLORS NUMBERS

DOES YOUR CHILD SEEM TO HAVE DIFFICULTY REMEMBERING ABC'S, COLORS, OR NUMBERS YES/NO

PLEASE PROVIDE ANY OTHER INFORMATION YOU FEEL WOULD HELP US TO GET TO KNOW/UNDERSTAND YOUR CHILD.

_____

COMPLETED BY_____**RELATIONSHIP**_____**DATE**_____